Second Act

Improving the Quality of Life for Older Adults in Buffalo and Erie County

Erie County Department of Mental Health
Erie County Department of Senior Services
United Way of Buffalo & Erie County

Program Partners:

Catholic Charities
Compeer
Hearts & Hands: Faith in Action
Matt Urban Center
Meals on Wheels

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Is Anyone Better Off?

How do we know whether the services and programs we offer are really helping the people we serve? This question is more frequently being asked here in Western New York, across the United States and abroad. It is the question that sits at the heart of performance management efforts. These efforts are not new. Both government and private industry have done performance measurement of some sort for decades. The reasons we do performance measurement also have not changed. We want to know that our financial resources are being used effectively, and that the programs and services that we fund are having the impact we intend. The urgency to demonstrate effectiveness has only become keener as citizens increase their demands for greater accountability of how their tax dollars and charitable donations are being used.

Nationally, the federal government has typically led the movement toward greater accountability. From supporting the development of evidence-based programming to standardizing performance measurement, federal agencies have focused on building the capacity of the human service sector to incorporate effective practices locally. While federal agencies addressing aging issues have progressed in this area, they are not as far along as their counterparts in children and family services. And because many aging services are delivered by grassroots, neighborhood centers without adequate research capacity, communities are not benefitting from most of the known advances. In particular, our community has not collected uniform local data, therefore, we've gained limited knowledge on what works, where the gaps in service exist, and where to focus our limited resources. The scarcity of common data has resulted in a lack of consensus on the highest priorities and most effective practices.

In 2009, as part of a Community Health Foundation falls prevention grant project, staff from the Erie County Department of Senior Services was introduced to a new way of thinking about performance management—Results Based Accountability (RBA) as outlined in Mark Freidman's book, *Trying Hard Is Not Good Enough*. At the same time, staff at United Way of Buffalo & Erie County were receiving training using the same approach in an effort to move to Results Based Accountability in their RFP process. Subsequently, staff from the Erie County Departments of Senior Services and Mental Health, along with the United Way of Buffalo and Erie County, met to review the RBA model and saw ways it could be applied to evaluating the

outcomes of mutually funded services for older adults. We recognized that the strength of the Friedman model is its recognition that no one agency alone is responsible for, or can produce, the community wide outcomes we want to achieve. Rather, it is only through the coordinated collaborative effort of multiple groups and agencies that we can produce the results we seek for our community. To begin to move in this direction, we formalized our RBA efforts under the project name Second Act.

Second Act works to further four community results for Erie County's older adult population. Identified by the AdvantAge Initiative[1], these results are: maximizing independence for the frail and disabled; optimizing physical and mental health and well being; addressing basic needs; and promoting social and civic engagement. Together, we are working with our mutually funded agencies to develop performance measures of their programs in order to more effectively monitor how, and to what extent, their programs impact on these four goals.

This endeavor broadens and enriches our current performance measurement activities by expanding our efforts to not only measure how much we are doing, but also how well we are performing and whether our programs are making a difference in the lives of seniors. It complements the work that is already being done to assess program effectiveness, and allows us to more effectively evaluate the efforts of our subcontractors. At a time when agencies are being asked to do more with less, and to provide more evidence of program efficiency and effectiveness, revisiting how we think of performance measurement is essential. Pursuing more systematic evidence of program effectiveness allows us to demonstrate that we are using resources to maximize their impact on the lives of seniors, positions us to advocate more successfully, and prepares us to meet the demands of the expanded performance measurement regime that the Obama Administration has put in place.

Since implementing the Results Based Accountability approach through the Second Act partnership, we have had opportunities to share our process, successes and areas for improvement with our colleagues across the state. Representatives from Erie County Senior Services and United Way of Buffalo & Erie County have been accepted as conference speakers and provided consultation at the following events:

Is Anyone Better Off, presented by Diane Oyler, PhD. and Mary K. Comtois, New York State Adult Abuse Training Institute, September 2010

Consulting on Collaboration and Coordination Planning Work team, Mary K. Comtois, New York State Adult Abuse Training Institute, November 2010

Is Anyone Better Off, presented by Diane Oyler, PhD. and Mary K. Comtois, New York State Aging Concerns Unite Us Conference, June 2011

Your Work Counts. Can You Prove It, presented by Karen Finn, Diane Oyler, PhD., and Nichlas Fox, National Adult Abuse Training Institute, September 2011.

It is our hope that funders of aging programs across the state, and nationally, replicate this process in their own communities using Results Based Accountability as the framework to build a strong partnership with the community. Unless we are all directing our limited funds toward common results and strategies, we won't produce the changes we seek for the aging population we serve. And as this population grows with the aging of the baby boomer generation, there is a greater urgency to act.

In the pages that follow we present a snapshot of some of Second Act's work in progress. For each one of the community results, we present a short summary of the issue areas we are focusing on along with community indicators we have identified, performance measures we have developed, and strategies that research suggests can help to make progress on our common outcomes. It is our hope that we will one day look back on this document and be able to proudly point to improvements we have made after its publication—improvements in measurement, improvements in community indicator availability, and most importantly improvement in delivering services that support happy, healthy, independent older adults.

Community Results

Quality of Life Result: Older Adults are Socially and Civically Engaged

What Does This Look Like?

Older people in our community are physically active, socially engaged, and spiritually uplifted. The community fosters meaningful connections with family, neighbors, and friends; promotes active engagement in community life; provides opportunities for meaningful paid and voluntary work; makes aging issues a community-wide priority.

Why is this important?

The World Health Organization (2002) recognizes social participation and involvement as a key component of aging well, and it is widely accepted that social support has a strong protective effect on health[2]. Among older adults, social support mitigates the effects of stress and reduces medical visits[3]. However, an increasing amount of seniors are at risk of being socially isolated or lonely; social isolation puts older adults at increased risk for disability and early death, and is linked to a decline in both physical and mental well-being[4]. Older adults without support systems are more likely to use emergency room services, and poor health can further reduce an older adult's ability to participate in social activities. Extreme loneliness appears to be a predictor for rural adults entering nursing homes, and some studies have even found that age itself is correlated with greater loneliness[5].

Social Engagement

Social engagement can be visiting with family or friends, participating in religious services or other formal organizations, and active leisure activities like attending classes, lectures, plays or concerts, playing cards, eating outside the house, and participating in sports. Participating in social activities allows older adults to exercise their competence, to enjoy respect and esteem, and to maintain or establish supportive and caring relationships. Low social engagement is a risk factor for cognitive impairment in the elderly, and is associated with a more rapid rate of motor function decline[6] [7].

Multitudes of international studies have found that quality of life increases with greater social engagement[8]. A 1999 study of more than 2700 seniors who were followed for 13 years found that not only was social activity as beneficial as physical activity, but that the more physically inactive the seniors were, the more benefit that was gained from social activities. High levels of social engagement are associated with lower depression[9] and with greater adult cognition[10]. Participation in religious activities, in particular, is associated with better quality of life and health outcomes in older adults, most specifically in the maintenance of cognitive function[1112]. Church attendance has also been found to moderate depressive symptoms, particularly among older women who are already depressed[13 14].

Evidence suggests that there is room to improve the participation rates in these types of activities. For example, Ralston (1991) found that only 15% of adults over the age 65 attended a senior center in the previous year[15]. A more recent survey of older adults in Missouri found a participation rate of only 8.3%[16]. Furthermore, the Pew Research Center's Forum on Religion & Public Life found that although older adults have the highest percentage of weekly religious attendance (53%), New York, in general, is a state with low attendance, with only 32% attending church services once or more a week[17].

Volunteering

Volunteering provides an opportunity for greater social connectedness by providing seniors the opportunity to bond with others, and talk with individuals who share the same conditions and acquire new coping strategies[18]. Involvement in meaningful social interactions helps older adults counter loss.[19] It is an important means of socialization that can improve life quality and self-worth, and promoting personal growth[20]. Seniors who volunteer often report an increase in relationships, friendships, social ties, and strengthened social support[21 22]. They feel they have more structure in their lives, are less lonely, and have more social resources[23].

Mentally, older adults who volunteer improve their self-esteem [24,25], report fewer anxiety and depression symptoms[26], higher life satisfaction [27], and better personal control than non-volunteers[28]. Volunteering can provide overall improved mental well-being, mental health, and quality of life[29]. Benefits extend to volunteer service recipients, volunteers, and their families[30].

Volunteering is also associated with a multitude of health benefits. Not only is volunteering correlated with lower morbidity rates, but volunteers are less likely to smoke, to have more moderate alcohol use than non-volunteers[31 32], perceive their own health as better, and watch less TV[33]. Many seniors also experience reduced pain[34], less decline in walking speed, enhanced muscular strength[35], and increased physical function[36].

Finally, senior volunteering is an integral part of the economy. In 2010, 26.4 million seniors gave 5.6 billion hours of their time to nonprofits and other organizations – a value of $77.2 billion, and increased the total charitable impact by more than 50 percent[37 38].

Indicators – How are we doing?

Statistic: 19% of adults in Erie County report inadequate social support, higher than the US (14%), and lower than New York State (24%).[39]
Goal: Increase social connections that provide social and emotional support.

Statistic: 11 recreational facilities per 100,000 Erie County residents, lower than the national rate of 16:100,000.[40]
Goal: Encourage development of community recreational options.

Statistic: 27.1 % of senior are volunteering in Buffalo, (2010) Buffalo volunteer rate is higher than NYS (21.4%), lower than US (26.3%), and lower than peer city of Rochester (36.7%)[41]
Goal: Increase volunteer rates for older adults 65+

Statistic: On average, 24.6 hours a year are spent volunteering in Buffalo, (2008-2010); Buffalo average volunteer hours per resident is lower than the US overall (26.8)[42]
Goal: Increase average volunteer hours per resident

Strategies That Work:

Program Development[43]

- Supporting transportation initiatives for seniors
- Using remote communications to reduce isolation
- Increasing community awareness of services for seniors
- Supporting informal caregivers
- Increasing the service delivery capacity of small community agencies
- Supporting the development of volunteer based outreach programs

Work towards the development of aging-friendly communities[44]

- Make sure age is not a significant barrier to lifelong interests and activities
- Support and accommodate individuals with age-related disabilities to meet basic health and social needs
- Make sure opportunities exist for older adults to develop new sources of fulfillment and engagement

Performance Measures--How Well Did We Do It?

% of volunteers fully trained
Average number of hours of service by agency volunteers
Cost per unit
% of referrals matched within 30 days
% of volunteer retention
% satisfied with volunteer activity
Revenue saved by maximizing use of volunteers for service delivery

Performance Measures—Is Anyone Better Off?

and % of clients reporting an increase in social connections.
and % of clients reporting they always or usually get the social and emotional support they need
and % of client or volunteers reporting feeling they have a valuable role in the community.
and % of volunteers with improved participation in civic, cultural, religious, and recreational activities.
and % of volunteers reporting they feel they improved the lives of the people they served.

Quality of Life Result: Seniors' Basic Needs are Addressed

What Does This Look Like?

The community provides appropriate and affordable housing; safe, accessible transportation; safe, quality neighborhood life with critical government services; quality medical care; accessible home support services such as home delivered meals, chore services)

Why is this important?

Housing:

Housing is a crucial component to safety and well-being, and there is a definitive link between appropriate housing with independence and quality of life for older adults. However, most seniors find there are limited choices for housing, particularly when they wish to stay within their community. Many older adults have no desire to leave family members or neighbors, but their current housing options often suffer from poor design. Areas such as walkways without adequate space for wheelchairs or bathrooms that are difficult to navigate are examples of layouts that may lead to falls. Common areas like staircases are often dark, narrow, or crowded. Older adults often find making modifications to existing housing to be expensive and difficult. Further, housing maintenance is a major barrier. Older adults worry about the cost, difficulty, and even the danger of allowing someone to do maintenance work within their homes[45].

Another major barrier for older adults is housing cost burden, or when housing and utility expenditures exceed 30% of household income. In the past twenty years, housing cost burden for older adults has risen 7%.On average, those 75 and older spend nearly 40% of their income on housing. 40% of senior households have one or more problems with housing cost burden, physically inadequate housing, or crowded housing, which is slightly higher than the US average[46]

Transportation and Access to Services:

The World Health Organization recognizes transportation as a determinant of health. Seniors without affordable and accessible transportation face isolation, reduced quality of life, and economic hardship. A 2004 study of American seniors age 65 and older found those who no longer drive make 15% fewer trips to the doctor, 59% fewer trips to shop or eat out, and 65% fewer trips to visit friends and family[47]. Giving up driving is associated with a decrease in out-of-home activities and increases in loneliness and immobility. Health status, well-being, and even survival can be profoundly affected[48]. Further, nearly 80% of seniors live in car-dependent suburban or rural areas, making access to services even more difficult[49].

In 2010, the Center for Neighborhood Technology (CNT) analyzed the quality of public transportation in 241 metro areas with populations of 65,000 or more. Not only did more than 11.5 million older Americans live with "poor" transit access in 2000, but this figure will be more than 15.5 million by 2015; in the Buffalo-Niagara Falls area alone, 49% of those 65 to 79 will have poor access to transportation[50].

Even when public transportation is available, it can be difficult for seniors to access. Common challenges include difficulty scheduling rides, inability to get into vehicles, limited availability of services, lack of flexibility in fixed routes, demand for expanded service, and paying for the costs of transportation[51].

Diet and Hunger

In 2010, 11.4% of the elderly population was food insecure; over five million older Americans[52]. Older adults were more likely to be food insecure if they were living below or at the poverty line, a high school dropout, African-American or Hispanic, divorced or separated, or living with a grandchild[53]. Older adults who are food insecure are more likely to be at nutritional risk, to have lower intakes of energy, major vitamins, and vital nutrients, and are more than twice as likely to report fair/poor health status than food secure counterparts [54]. Malnutrition puts older adults at risk for poor wound-healing; weakened immune systems, which lead to greater risk of infection; and muscle weakness, which can lead to falls and fractures[55]. Food insecure seniors are also more likely to have reduced functional status in Activities of Daily Living (ADLs), causing a disparity between "actual" and "physical" age – for example, a 64-year-old suffering hunger will likely have the ADL limitations of a 78-year-old.[56].

Even when benefits exist, elderly people may not take full advantage; as evidenced by participation in the Supplemental Nutrition Assistance Program (SNAP), with only one-third of eligible older adults receiving benefits[57]. Older adults are also less likely to know where to apply

and are less likely to have previously received food stamps. Older adults also worry about how they will be perceived by grocery store staff, other shoppers, friends, and family if they avail themselves of help: 76% report feelings of stigma, and 67% said a major reason they did not used SNAP was because they felt embarrassed[58].

Even when older adults are food secure, many do not eat healthy enough to meet federal diet quality standards. Though the average older adult meets the requirements for whole fruit, total grains, and meat and beans, they fall short in nine other dietary components. Further, the average older adult's intake of saturated fat, sodium, calories from solid fats, alcoholic beverages, and added sugars is often too high to meet health quality standards. A healthy diet reduces cardiometabolic risk factors, such as hypertension, diabetes, and obesity, and dietary improvement in older adults can lead to reduced disease risk and overall improved health[59].

Indicators – How are we doing?

Statistic: 8% of elderly living alone are food insecure.[60]
Goal: Decrease the percentage of food insecurity among seniors

Statistic: Nationally, 34% of eligible seniors receive food stamps[61]
Goal: Increase the number of eligible older adults receiving food stamps

Statistic: 70% of older adults in the City of Buffalo are very or extremely concerned about being able to afford housing costs.[62]

Statistic: 18.1% of New York homeowners with mortgages, 50 and older, have housing costs in excess of 50% of household income. 10.2% of renters have housing costs in excess of 50% of household income.[63]

Statistic: New York State is the third least affordable state for older adults to live (based on housing costs, health care, transportation, food, and miscellaneous essentials).[64]

Goal: Reduce the percentage of seniors reporting problems with housing, including cost, overcrowding, and physical inadequacies

Statistic: 40% of rural residents do not have access to public transportation options[65]
Goal: Increase alternative transportation options for older adults.

Statistic: Non-driving older adults taking 15% fewer trips to the doctor than their driving counterparts.[66]
Goal: Increase alternative transportation options for older adults.

Statistic: 7% of Erie County residents have limited access to healthy foods (compared to 4% in New York State).[67]
Goal: Increase access to transportation for grocery shopping.

Strategies That Work

Housing[68]

- Promote policies and programs that increase affordable housing for all older adults
- Increase housing that is made with sufficient space to enable older adults to move freely
- Promote housing that is adapted for older people, with appropriately designed bathrooms, toilets, and kitchens
- Encourage appropriately qualified and reliable service providers to undertake maintenance work for older adults
- Ensure that public housing, rented accommodations, and common areas are well-maintained

Transportation and Access to Services[69]

- Strengthen coordination of federal, state, and local transportation programs through better planning and service integration
- Promote mobility management
- Create communities for all
- Improve safety
- Encourage the development of community-based transportation programs

Diet and Hunger

- Support SNAP and other program outreach targeted towards seniors[70]
- Increase availability and affordability of healthier food choices in public service venues
- Improve the geographic availability of supermarkets in underserved areas
- Encourage community gardens[71]

Performance Measures--How Well Did We Do It?

% rating the program excellent or very good
% reporting services are a good value for the cost (meals, homecare, day care).
% reporting they are satisfied with the quality of service
Reduction in time on wait list for “at risk” demographics
% of respondents reporting that case manager handled call in an excellent manner
% of respondents reporting that the information sent was clear and understandable
Cost per unit

Performance Measures—Is Anyone Better Off?

and % of clients where requests lead to a successful referral or linkage

and % of clients where services contributed to a client or loved one remain at home and/or community of choice
and % of clients with a reduction in unmet needs for ADL and IADL
and % of clients with an increase in income or monetary benefits
and % of clients transported to the grocery store or famer's market to access healthy foods
and % of clients who eat at least one healthy meal each day
and % of clients at a healthy weight
and % of clients with a completed safety plan
and % of clients granted orders of protection
and % of successful prosecutions of perpetrators of family violence
and % of clients receiving expert forensic medical examinations to aid in prosecution of cases successful prosecutions

Quality of Life Result: Physical & Mental Health and Well-Being are Optimized

What Does This Look Like?

The community promotes healthy behaviors; supports community activities that enhance well-being; provides ready access to preventive health services; provides access to medical, social, and palliative services (includes services such as community support and health promotion).

Why is this important?

Disability and Chronic Conditions

In developed countries like the United States, the leading causes of death have shifted from "young age" causes like infections and parasitic diseases, respiratory infections, and perinatal conditions, to "old age" causes like cardiovascular disease and cancer, leaving most older adults with decades of life in which to deal with chronic conditions. Today nearly 80% of seniors have at least one chronic health condition; 50% have at least two; and 30% have three or more[72]. These chronic conditions can negatively impact quality of life, affect an older adult's ability to live independently, and impose economic hardship[73]. One in five people over the age of 65 have limitations in mobility or self-care, and one in six people over the age of 65 need help with or are unable to perform ADLs or IADLs[74]. Disability is a risk factor for dependency and institutionalization, and the cost of medical care for disabled older adults is three-times that of nondisabled older people[75].

Obesity and Exercise

In 1996, the U.S. Surgeon General recommended that Americans get at least 30 minutes of moderate physical activity daily, five or more days a week. Yet few older adults achieve the recommended minimum[76]. Inactive people are nearly twice as likely to develop heart disease as those who are more active, and many inactive people qualify as obese, which increases the risk of disability, decreases quality of life, and can even limit mobility in older adults[77]. Lack of physical activity may also lead to more visits to the doctor, more hospitalizations, and more use of medicines for a variety of illnesses[78].

However, even moderate exercise and physical activity can improve the health of the frail elderly, or those with chronic diseases like arthritis, heart disease, or diabetes[79]. Exercise is associated with a multitude of health benefits, including making muscles and bones stronger, improving endurance, maintaining balance, raising "good" HDL cholesterol, improving breathing, improving sleep problems, and increasing ability to fight infections. Exercise can also reduce the risks associated with heart disease, high blood pressure, diabetes, obesity, osteoporosis, colon cancer, gall stones, and injuries related to falls. Further, exercise can help to manage stress, improve mood, improve well-being, improve or maintain cognitive function, reduce feelings of depression, and reduce brain tissue loss. Finally, exercise can be a vital part of arthritis treatment, with some studies finding that exercise can reduce arthritis pain[80]

Falls

Despite most falls being preventable, one out of every three people aged 65 and older fall each year, with one older adult being treated in the emergency room for a fall every 17 seconds and one older adult dying from a fall every 30 minutes[81] [82]. Among older adults, falls are the leading cause of injury-related death. Further, risk of death is increased 20-25% in the year after suffering a fall in which a fracture is sustained, with women remaining at higher risk of death for as long as 4 years[83].

Fractures are more common among people who had lower mental ability scores, self-reported poorer health status, frailty, worse lung function, and cardiovascular disease. Among older adults living independently, about 75% of falls occur at home[84], and falls may force older people to move into nursing homes and may even lead to death[85]

The cost of falls in 2002 was more than $19 billion, with annual cost expected to reach $54.9 billion by 2020[86].The average cost of hospitalization is $17,500, and for those 72 and older this rises to $19,400, not including doctors' services. As the number and average age of older adults increase, both the number of falls and the cost to the U.S. health care system is expected to increase dramatically.

Access to Services

Medical services help detect many diseases, delay their onset, or identify them in their most treatable stages to ensure healthier, longer, and more productive lives for older adults. Yet

despite the effectiveness of these potentially life-saving preventive services, fewer than 40% of adults aged 65 years and older are up to date on these services. Findings by the CDC estimate that if older adults received even 20 of the 25 recommended preventive services, over two million more people would have been alive during 2006 without an increase in net healthcare costs. These services are paid for by nearly all insurance plans, including Medicare and Medicaid, yet older adults may not be aware of their coverage or what services are recommended for their age group[87].

Mental Health

Beginning in 1999, the Office of the U.S. Surgeon General identified older adults as a priority concern in its first report on mental health. More recently in 2005 the White House Conference on Aging adopted a resolution to improve recognition, assessment, and treatment of mental illness and depression among older Americans[88]. While older adults may face serious losses, persistent bereavement or serious depression is not normal and should be treated. Roughly 15% of older adults have experienced depression[89], and older adults accounted for 16% of suicide deaths in 2004, a disproportionately high rate[90].

Depression complicates chronic conditions such as heart disease, diabetes, and stroke; increases health care costs; and often accompanies functional impairment and disability. Chronically ill Medicare beneficiaries with accompanying depression have significantly higher health care costs than those with chronic diseases alone ($22,920 and $11,956 annually for those with and without depression, respectively) [91]. People with serious mental illness typically die 14 to 32 years earlier than the general population – a life expectancy roughly equivalent to sub-Saharan Africa – and suffer from higher rates of addiction, obesity, and poverty[92].

Indicators – How are we doing?

Disability and Chronic conditions, access to services, mental health, health promotion

Statistic: 26% of Erie County adults report no leisure time activity[93]
Goal: Increase the number of older adults participating in exercise

Statistic: 81% of Erie County's Medicare enrollees receive a diabetic screening, lower than the national rate of 89% and the New York State rate of 83%.[94]
Goal: Increase the number of older adults that receive Medicare funded chronic disease screening.

Statistic: 56 of every 1000 Erie County Medicare enrollees experience a preventable hospital stay. This is higher than the national rate of 49:1000, and lower than the New York State rate of 69:1000.[95]
Goal: Reduce the number of preventable hospital stays.

Statistic: Prevalence of financial exploitation of older adults in New York State—7.6%; Prevalence of non-financial elder mistreatment in New York State—4.6%.[96]

Goal: Reduce rates of all categories of elder abuse.

Statistic: 30.6% of women age 65 and older are obese (2003-2006); 28.7% of men age 65 and older are obese (2003-2006)[97]

Goal: Reduce the prevalence of obesity by encouraging exercise and healthy eating.

Statistic: On average, Erie County adults report 4.1 poor physical health days in previous 30 days, compared to 2.6 nationally, and 3.5 in New York State.[98]

Goal: Reduce the number of reported poor physical health days.

Statistic: Unintentional falls reported**:** 4,116/100,000 age 85+, 1566/100,000 age 65-74 and 3892/100,000 ages 75-84 in Erie County, (baseline: 2006-2008).[99]

Goal: Decrease the rate of unintentional falls of older adults resulting in hospitalization/ED visits

Statistic: On average, Erie County adults report 3.5 poor mental health days in previous 30 days, compared to 2.3 nationally, and 3.4 in New York State.[100]

Goal: Reduce the number of reported poor mental health days.

Strategies That Work:

Disability and Chronic Conditions[101,102]

- Promote healthy behaviors and systemic changes to improve the health of those with chronic conditions
- Work with health care providers to increase use of self-care management and other tools by individuals with chronic conditions.
- Encourage employers, assisted living facilities, and community centers to implement chronic disease management programs

Obesity and Exercise

- Create or enhance access to places for physical activity (walking trails, access to exercise facilities)[103]
- Offer health behavior education, risk factor screens, referrals to physicians or additional services, health and fitness programs, and support or buddy systems
- Create community-wide campaigns involving many community sectors and using broad-based, multi-component strategies[104]

Falls

- Develop policies to prevent falls in long-term care facilities and public places

- Create community-based strategies that combine exercise programs with education sessions
- Increase provider knowledge about fall risk assessment and fall prevention
- Identify older adults at risk of falling and refer them to local programs and resources[105]

Access to Services/Lower Utilization of Acute Care

- Utilize comprehensive assessment tools to identify medical and social needs
- Public health should develop and support better methods and systems to monitor health outcomes related to older adults[106]
- Promote policies to increase community access to services
- Build awareness of programs and services through media
- Identify people in need using multiple formal and informal channels (such as block clubs, faith-based organizations, and human service agencies)
- Link people in need to case management services
- Expand use of evidence based programs such as Transitions in Care

Mental Health

- Provide routine screenings to identify adults who are depressed and direct them to appropriate treatment [107]
- Increase trained depression care managers and patient education for home-based care[108]
- Increase public knowledge about depression in later life
- Increase primary care knowledge about resources and referrals to appropriate mental health care[109]

Performance Measures--How Well Did We Do It?

Fidelity measures for evidence based programs
% improvement in demographic targeting (race/ethnicity)
Staff to client ratio
Cost per service unit
Ave # of days on wait list

Performance Measures—Is Anyone Better Off?

and % of clients with limitations or risk improve in physical condition or functioning
and % of clients with limitations or risk improve in mental condition or functioning
and % of clients demonstrating improved health management skills
and % of clients regularly attending health-related appointments
and % of clients transported to medical appointments
and % of clients who eat at least one healthy meal each day
and % of clients transported to the grocery store or farmer's market to access healthy food
and % of clients physically active an average of 30 minutes each day, five days per week
and % of clients at a healthy weight

and % of clients with reduced function who engage in light, moderate, or vigorous leisure-time activities
and % of clients reporting improvement in connecting with natural supports

Quality of Life Result: Independence is Maximized

What Does This Look Like?

The community mobilizes resources to facilitate "living at home" and access to services in the community that support independence. This includes, but is not limited to, providing accessible transportation; supports family and other caregivers; and extensive case management.

Why is this important?

In-Home Care

According to Genworth Financial's 2011 Annual Cost of Care Report, two-thirds of people over 65 years of age will need some form of long-term care. Not only is long-term care expensive, but Medicare only pays for it in certain circumstances that do not cover chronic illnesses and disabilities[110].

However, there are a multitude of benefits associated with in-home care. Older adults who get in-home care develop fewer complications, such as infections, because they are not exposed to the germs commonly found in hospital settings. Home settings are also typically more reassuring, comfortable, and non-disruptive than busy hospitals. Older adults are also more satisfied with their overall care, regardless of age, health, or income; they are more satisfied with their physicians and with the comfort and convenience of care than older adults in traditional hospital settings. Relatives of patients who receive in home care are also more satisfied than relatives of patients who receive care in a traditional hospital setting[111].

This is equally true for older adults with "geriatric syndromes" like falls, depression, or chronic illnesses, in which comprehensive care is important. Adults who receive home-based care receive higher-quality medical care, report better health-related quality of life, and end up in the emergency room less often than those who got standard care. There was also a decrease in hospital admissions in the sickest group of patients[112].

In-home care is also a cost-saving measure. Between 1990 and 2001, nursing home and home health-care expenditures doubled to $132 billion, with public programs like Medicaid and Medicare paying 57% of the cost. From 2000 to 2020, public financing of long-term care is expected to raise 20-21%. Yet on average, community-based long-term care is one-third the cost of comparable nursing home care. Further, the National Institutes of Health estimates that

the ability to delay nursing home entry nationwide by even one month would save the country $3 billion annually[113].

Caregivers & Caregiving

Over 57% of older adults rely entirely on unpaid help, and another 36% on a combination of paid and unpaid help[114]. On average, informal caregivers provide 18 hours of care per week, and 40% provide at least 40 hours of care a week. Twenty-two percent of caregivers assist two individuals, while 8% are caring for three or more[115].

There are both personal and economic costs to caregiving. Caregivers run higher risks of depression, anxiety, and other health problems. Struggling caregivers are more likely to move older adults to nursing homes or other institutions than caregivers who are having less difficulty[116]. More than 50% of caregivers have to change their work schedule to more flexible or less work hours, and 50% of caregivers who were employed have to temporarily or permanently give up work. A study by the National Alliance for Caregiving and the National Center for Women and Aging at Brandeis University estimated that caregivers lose $659,000 in lost wages, Social Security benefits, and pension benefits over a lifetime[117]. In 2009 alone, the estimated value of caregiving in the United States was approximately $450 billion[118].

As more people survive to older ages with chronic diseases and disabilities, more middle-aged and younger people will be needed to care for their relatives[119]. There is a projected growth in the elderly support ratio, or the number of people aged older than 65 to the number of people aged 20-64 years. If this ratio continues to grow, fewer young and middle-aged adults with be available to provide informal care. As it is, 50% of all current caregivers are over age 50 themselves[120].

Indicators – How are we doing?

Statistic: 78% of adults in need of long term care who are living in the community depend on family and friends as their only source of help.[121]
Goal: Provide caregiver support, counseling, and training to help sustain informal care giving.

Statistic: U.S. caregivers spend an average of 20 hours per week providing care. 13% of family caregivers provide 40 hours or more per week.[122]
Goal: Provide caregiver support, counseling, and training to help sustain informal care giving.

Statistic: 23% of family caregivers caring for a loved one for 5 or more years report their health is fair or poor.[123]
Goal: Augment informal care giving with formal supports and respite to ease caregiver burden.

Statistic: 4.3% of the 65+ population in New York State are Nursing Facility residents[124]
Goal: Decrease the demand for skilled nursing beds.

Statistic: 818/1000 85+, 132 per 1000 65-84 in Erie and Niagara Counties, 2007.[125]
Goal: Decrease the demand for skilled nursing beds

Strategies That Work

In-Home Care

- Continue to develop formal services, including the use of volunteers in support of caregivers
- Link people to formal and informal supports (such as block clubs, faith-based orgs, human service agencies)
- Utilize comprehensive assessment tools to identify medical, physical, and social needs
- Employ variety of services that support independence (meal delivery, case management, transportation)
- Market services available and how to access them when needed
- Create new strategies to serve hard to reach clients. These include, but are not limited to developing consumer directed care, as well as alternatives to traditional home care such as expanded chore services through the area agencies on aging.

Caregivers & Caregiving[126]

- Develop home assessments for specific needs for caregivers
- Promote person- and family-centered care
- Advocate for "family-friendly" workplaces with flextime, telecommuting, and caregiver support programs.
- Encourage health professionals to consider caregivers as part of the care team

Performance Measures--How Well Did We Do It?

% of clients reporting excellent or very good overall quality of case management services
Case manager to client ratio
% of clients linked to home and community based services
% rating transportation services they receive excellent or very good.
Cost per service unit
% of budgeted funds expended on services

Performance Measures—Is Anyone Better Off?

and % of clients where services contributed to a client or loved one remaining in the community

and % of clients with a reduction in unmet needs for ADL and IADL

and % of clients with an increase in income or monetary benefits

and % of clients or familial caregivers demonstrating improved skills navigating the health and human services system

and % of familial caregivers demonstrating improved care giving skills

and % of familial caregivers demonstrating improved advocacy skills

and % of familial caregivers with improved relationship with care recipient(s)

Select Partner Outcome Summaries

Second Act
Outcome Summary

Project AIM statement: Project partners will be able to evaluate programs using consistent evaluation criteria across target populations served by Erie County Departments of Senior Services and Mental Health, and the United Way of Buffalo and Erie County.

Project Plan: Develop a common menu of performance measures that would be incorporated into agency RFPs, and used to measure progress toward contract goals. Also, to work toward developing a performance management culture in funded community agencies that will encourage the use of performance data to drive quality improvement efforts.

Project Partner: United Way of Buffalo & Erie County

What steps did your agency take to further the project plan?

Following our 2009-11 funding process, the United Way recognized the need to build the capacity of program staff serving seniors, especially as it relates to their ability to measure program results. While evaluating applications submitted under the United Way Health Platform, and comparing responses of programs addressing children youth and family issues with programs serving the aging population, the discrepancy noted in the quality of responses was significant. United Way staff met with representatives from Erie County who had participated in the funding decision process and who had also voiced concerns over the quality of applications.

After the decision was made to use the Results Based accountability framework to guide our joint efforts, United Way sponsored an RBA training session for non-profit agencies interested in incorporating RBS evaluation principles. Partner members of Erie County Senior Services and Mental Health also attended the sessions giving each of us a firm grounding in its theory and application.

Since that time, United Way has integrated RBA on multiple levels within the Community Impact Department work from community planning efforts to assessment of funded agency program performance. Senior focused programming applying for funding through the United Way select performance measures from a common menu developed by Second Act.

United Way has recruited interns through the UB School of Social Work Hartford Fellowship Program to work directly with the Second Act team. Interns have provided support in conducting focus groups, verifying measures and documenting initiative efforts.

What did your agency learn from the process?

We discovered there are significant limitations in finding reliable sources of local community-wide data. Data development is an area where we would like to devote more resources, but competing priorities make it difficult. The WNY Community Health Planning Institute has started focusing on senior issues and we plan to take advantage of this resource in the upcoming year.

We also found that data was not being collected in a consistent manner at the program level. In fact, in many cases, standard measurement tools don't exist on a local, state or national level leaving this area open to interpretation by individual agency program staff. We continue to work with UB's Uniform Data System staff as they develop measurement tools to fill the gap.

What next steps will your agency take to address what you learned?

United Way continues to support the Second Act initiative, dedicating staff resources to facilitate the multi-stakeholder effort to strengthen the older adult human service sector and improve quality of life.

United Way is holding RBA Continuous Improvement Sessions, as a component of the Program Investment process. As such, we will share lessons learned from these sessions with our Second Act partners.

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Project Partner: Erie County Department of Senior Services

What steps did your agency take to further the project plan?

The Department of Senior Services is now entering its third phase of RBA integration. During the 2010-11 service year, the Department tested the feasibility of using RBA to measure program performance through two pilot projects—one with Hearts and Hands, a neighbor helping neighbor volunteer based program, and the other with the Matt Urban Center, a neighborhood based agency that delivers case management services for the Department.

Early indicators suggested that RBA would be a beneficial way to assess our programs. Given that, the decision was made to incorporate RBA performance measures into all our case management contracts for the 2011-12 service year. Case management agencies were asked to select from the common menu of performance measures developed by Second Act. A number of trainings were held to help agencies navigate new reporting requirements. Feedback was solicited throughout the process from Senior Case Managers who supervised the contract agencies.

For the 2012-13 service year, the decision was made to continue the use of RBA with our case management agencies. In Phase 3, we have moved toward more uniformity of performance measures by limiting case management agencies to three specific performance measures that we believe are the most useful for assessing client outcomes.

What did your agency learn from the process?

We have learned a number of things during the time that the Department has been using RBA. Perhaps the most valuable lesson was that efforts needed to be made to ensure that data was being collected and coded consistently by all subcontractors. We also learned that some performance measures are more useful to us than others. Based on that, we made the decision to focus on a smaller number of measures.

Process wise, we learned that we need to do more, as a Department, to communicate back to the agencies in terms of performance. We've also modify our thinking on which staff members are the

most appropriate liaisons on this effort. Initially we had identified our contract monitoring staff, but found that senior case managers where better equipped to address questions and concerns as they have more advanced knowledge of the service being assessed.

What next steps will your agency take to address what you learned?

The Department is committed to continuing to use RBA to measure the performance of our case management contract agencies. We are also beginning to make steps toward using RBA to assess other services including transportation, and in-home support services.

Members of the Department are also working to advance a 'performance management' culture within the department so that we continue to use the data we collect for program improvement, and more fully incorporate it into our contract monitoring and program evaluation efforts.

Understanding that the ultimate success of Second Act will depend on building capacity in our non-profit community, we are also working on identifying ways to strengthen the skills needed to do meaningful performance management.

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Project Partner: Hearts and Hands

What steps did your agency take to further the project plan?

Hearts and Hands' Executive Director became a member of the Second Act Steering Committee with a goal to provide insight to this project from the perspective of a funded program. Our main interest was to help direct the creation of common performance measures across funders to ease the grant management burden on organizations with multiple funding streams while developing tools that would aid in guiding quality improvement of program and services.

As a Program Partner, we collaborated with similar service agencies to provide insights on key indicators and performance measure in the areas of civic engagement and basic needs. We than developed survey tools in both areas and tested them amongst our constituents.

What did your agency learn from the process?

It became evident through this collaboration that there are common threads across programs and key indicators that can provide funders and the organizations themselves with performance measures to aid in guiding quality and efficiency improvements in their programs to better serve their constituencies.

What next steps will your agency take to address what you learned?

We will continue to improve our survey tools and the methodology of their distribution and collection. Even though current results show a very high satisfaction amongst our constituency and reflect a strong impact of our services, we would like to see a higher response rate of our survey tools. A higher return rate will provide a more significant statistical result and confidence in their measure.

We look forward to adding these performance measures to our Board of Director's organization dashboard of key indicators to aid them and agency leadership as they continue to guide Hearts and Hands growth and delivery of quality programming.

Second Act
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Project Partner: Erie County Department of Mental Health

What steps did your agency take to further the project plan?

The Erie County Department of Mental Health in collaboration with the Erie County Department of Senior Services, the United Way of Buffalo and Erie County, and providers met to determine defining principles/core values for service provision, community valued results and related performance measures for Older Adult Services in Erie County.

As a result the Erie County Department of Mental Health forwarded a Request for Proposal to community stakeholders to apply community valued results through the implementation of Research Informed Practices and utilizing the identified performance measures in the proposed areas.

Recipients awarded through the RFP demonstrate the ability, commitment and contractual obligation to rigorously evaluate their performance against the performance measures designed through the Second Act Project by submitting a Quality Improvement Plan (QIP) that support frequent performance evaluation against the identified performance measures. Quarterly reporting against the agreed upon Performance Measures, other data and ongoing QIP is required.

Programs designed include Care Coordination, Geropsychiatric Assessment Program (GAP), Elderly Wrap Around Program (E-WRAP), and Compeer services which support the headline and secondary measures within the Community Valued results: Social and Civic Engagement, Basic Needs Addressed, Physical and Mental and Wellbeing Optimized, and Independence Maximized**.**

What did your agency learn from the process?

Approximately one and half years after implementing Older Adult Services via the Second Act Project and ECDMH RFP, we have begun to evaluate performance measure data collected through the use of a dashboard. Service providers have access to data reports (specific agency and community) through the Program Contract and Management System (PCMS) which supports transparency of performance measure results and comparative analysis in like outcome areas.

What next steps will your agency take to address what you learned?

The Older Adult Services system partners meet quarterly and will begin to implement a learning community based on dashboard results to further develop and evolve the systems and services provided. Representatives from the service areas participated in the development of the Community Valued Results performance measures and are also becoming a part of the Second Act committee.

Second Act's Next Steps and Priorities

Capacity Building: Second Act will work toward building the capacity of our non-profit and public sector partners to do the work that is needed for good performance management. This requires ensuring that agencies are producing comparable data using reliable data collection methods, and using performance measures to steer quality improvement efforts.

Expansion: Second Act will work toward expanding the use of Results Based Accountability where appropriate within our collective sphere of influence. We will also continue to share our framework with our colleagues in other parts of New York State and across the country.

Data Development: Second Act will work toward improving the state of community indicators in Erie County. Currently, the availability of age-specific community indicators at the county level is significantly limited. Because such indicators are essential for performance management efforts, we will work to identify community partners who can assist in changing the current condition we face.

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